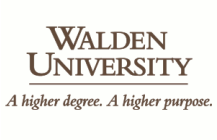

2018

Perceptions and Interpretations of Posttraumatic Stress Disorder Among Cambodian Immigrant Community

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Abstract

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MPH, Walden University School of Public Health, 2010

BA, California State University, Stanislaus, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

College of Health Sciences

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Abstract

Posttraumatic stress disorder (PTSD) affects more than 60% of Cambodian immigrants in the United States. However, researchers do not yet know why less than 5% of Cambodian immigrants are accessing mental health services. This qualitative study involved investigation of participants' perceptions of how PTSD is manifested in the Cambodian immigrant community to understand barriers to mental health services access. The social ecological theory provided a frame for understanding how traditions, values, culture, and beliefs affect Cambodian immigrants' perceptions of PTSD and the mental health system. Data was collected from semi structured interviews of 13 participants, 18 to 70 years of age, residing in Stockton, California, who shared their perceptions of PTSD. NVIVO was used to organize each data category for thematic analysis. The themes included: (a) hearing of PTSD, (b) meaning of PTSD, (c) contributing factors, (d) healing practices, (e) recognition of PTSD, (f) reactions, (g) reasons most often given, (h) encouraging family members, (i) healing practices, (j) ways of helping, (k) counseling, (l) medications, (m) mental health support, (n) mental health resources, and (o) want more information. The findings indicated that stigma continues to be one of the barriers in accessing mental health services, and that Cambodian immigrants have a strong desire to learn more about mental health and mental health services in San Joaquin County. Results from this study contribute to an area of mental health research that is limited, and they may be used by researchers and mental health practitioners to improve cultural understanding and awareness among diverse communities and help reduce the stigma regarding mental health issues.

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Dedication

My doctoral study is dedicated first and foremost to my Higher Power, Buddha, spirits of my ancestors and loved ones. Thank you for watching over me and blessed me with an incredible life, unconditional love, family, courage, faith, spirituality, and humility.

To my mom, Chomroeun Sap and my dad, Sareth Roeum, you are truly the wind beneath my wings, my symbol hope and resilience. The Cambodian genocide took so much from you, but it did not weaken your passion, compassion, love, generosity, courage, kindness, and human spirit. Your unconditional love, sacrifices, support, faith, and encouragement lifted me through my toughest moments in life. I love and honor you.

To my husband, who has been by my side throughout this journey, thank you for being my anchor and refused to let me quit. To my beloved children, Rainne, Roeum, Rhaiya, Raiyah, and River, you are the light of my life. Thank you for being the sweetest, funniest, loving, caring, kind, thoughtful, and affectionate little human beings. You make Mommy's heart smile every day. To my sisters, Phetkadai and Morackot, I cannot be more grateful to have you in my life. Roeum Sisters Forever! To my Mother-in-Law, Susan Milleman, thank you for your love, support, laughter, understanding, and encouragement. I am grateful for everything that you have done for us. To the rest of my families, near and far, I love you.

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God and the Universe, thank you for your love, guidance and protection. No matter what life may bring, I know you will stand beside me, guiding me, and carrying me through. This dissertation was a huge awakening for me mentally, emotionally, physically, intellectually, interpersonally, socially, professionally, and spiritually. I promise to give back, pay it forward, and be an instrument of positive social change.

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To my all my teachers, mentors, and friends, thank you for being a part of my life and this journey. To all the Cambodian communities across the globe, I am honored to be among you. We are strong, loving, resilience, talented, rooted, caring, and generous people. We will find hope and healing together. No matter who we are, what we are, where we come from, or who we worship, we all want to love, be loved, and have a sense of belonging. Love is the essence of hope and humanity. Without humanity, there will be no peace in this world.

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Chapter 1: Introduction to the Study

Background

According to the United States Census Bureau (2013), mental illness is the leading cause of disability in the United States. Mental illness has been recognized as a bona fide public health issue, no less worthy of attention, research, and remediation than any other serious matter relating to the general health and welfare of the public (United States Department of Health and Human Services, 2015). The National Institute of Mental Illness (NIMI, 2013) has indicated that every year approximately 57.7 million Americans over the age of 18 years have a "diagnosable mental health disorder" (NIMI, 2013). Of these people, approximately 8% (4.7 million) are diagnosed with posttraumatic stress disorder (PTSD; U.S. Department of Veterans Affairs, 2015).

PTSD is "a disorder that develops in some people who have experienced a shocking, dangerous, and traumatic event" (National Institute of Mental Illness, 2015, p. 1). The *Diagnostic and Statistical Manual of Mental Disorders (*5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) defined PTSD as having criteria including "a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity" (p. 345). In addition to the symptoms, it is imperative to consider the time frame of when the symptoms occurred and the person's level of daily function, and to ensure that the symptoms are not attributable to other co-occurring medical conditions or substances (APA, 2013).

Friedman (2013) identified four types of PTSD symptoms: "reliving the event

(also called re-experiencing symptoms), avoiding situations that are reminders of the event, negative changes in beliefs and feelings, and feeling keyed up (also called hyperarousal)" (p. 2). Friedman explained that symptoms of PTSD may disrupt life, lower levels of functioning in daily activities, and make getting through the day difficult. In Chapter 2, I offer further explanation of PTSD symptoms.

While awareness of PTSD as a mental health concern has increased among the general population, few researchers have focused on the knowledge shared by immigrant communities from different cultural backgrounds, especially among the first-generation immigrants affected by this phenomenon through their exposure to trauma during war. Marshall, Schell, Elliott, Berthold, and Chun (2005) reported PTSD as a public health issue that affects immigrant communities and observed that the highest prevalence of PTSD is among the Cambodian immigrant. Additional research has shown high prevalence of PTSD among newly arrived refugees and immigrants; however, the number of individuals accessing mental health services for help is low, especially for Cambodian immigrant communities (San Joaquin Behavioral City Data, 2012). Therefore, the purpose of this qualitative research was to investigate the cultural understanding and interpretation of PTSD by Cambodian immigrants in Stockton, California.

Background and Historical Context

Cambodian Refugees and Immigration

Between 1975 and 1979, Cambodians faced one of humanity's most brutal and traumatic atrocities since the Jewish Holocaust (Boehnlein & Kinze, 1996). The total population of Cambodia in 1975 was 7.1 million. After 4 years under the communist

Khmer Rouge regime, less than two-thirds of the population survived (Kiernan, 2012). During the Khmer Rouge era, known as the Cambodian Genocide, men, women, and children were indiscriminately subjected to hard labor, starvation, and torture. The goal of the Khmer Rouge was to eliminate the class system through mass killing of governmental officials, doctors, lawyers, nurses, teachers, monks, and anyone who had professional education or skills, or who simply possessed the ability to read or write (Kiernan, 2012). Ultimately, this relentless campaign of terror resulted in the deaths of more than 2 million Cambodians (Boehnlein & Kinze, 1996). Of those who survived the Khmer Rouge regime, many were displaced and left with no other option than to seek refuge in neighboring countries. Many survivors had been physically, mentally, and emotionally wounded, impairments contributing to the high prevalence of PTSD and major depression (Marshall et al., 2005).

The physical and emotional trauma endured during the genocide is only one source of trauma to which many Cambodian immigrants were exposed. Seldom discussed in the community are the events relating to the escape from the death camps and fleeing to neighboring countries. During such flight, many men, women, and children lost limbs and lives as the result of inadvertently treading upon explosive land mines and other concealed traps (Kiernan, 2012). Because of the severely damaged condition of practically every established highway, road, and bridge, and their inability to travel by any other means, secret travel by foot through the jungle was the only option for escape for many Cambodian refugees. Starvation and illness were common among virtually all survivors. Often, family members had to leave loved ones behind to save the lives of

other family members who might have had a higher likelihood of surviving (Kiernan, 2012).

Experiences such as these are not uncommon among Cambodian immigrants. In addition to the shared traumatic experiences, genocide also left many children without parents, thus resulting in a high number of orphans, the hardest hit Cambodian refugee population (Kiernan, 2012). Many of these orphans were victims of abuse and neglect during the genocide and in the refugee camps. Recent findings have indicated that the genocide destroyed more than the 2.5-3.8 million lives (Marshall et al., 2005). The genocide also transformed the family and social structure (Boehnlein & Kinze, 1996). Individuals who sought refuge in the United States found that building a life in the new country was another challenging experience because of the acculturation process of learning a new culture and language (Peou, 2013). While Dellanira, Simoni, Alegeria, and Takeuchi (2012) found no direct association between acculturation and psychological distress, acculturation does appear to indirectly affect other social factors, such as access to and use of mental health services. For those who experienced trauma during the war, lack of knowledge about the mental health system and cultural barriers continued to prevent them from receiving the help they needed (Marshal et al., 2005).

There are approximately 267,700 Cambodians living in the United States (U.S. Census Bureau, 2012). Stockton, San Joaquin County's largest metropolitan area, is made up of many diverse communities and ethno-cultural subgroups. Among these identifiable groups are those of Cambodian descent. Stockton is home to the third-largest Cambodian population outside of Cambodia's geographical borders with approximately 19,000

individuals in 2011 (Applied Survey Research, 2008). The Cambodian immigrant experience shared by those who have come to reside in Stockton is unique due to socioeconomic factors; however, information regarding the Cambodian immigrant community in Stockton is difficult to find due to the lack of research and desegregated data specific for this community. Marshall et al. (2005) argued that Cambodian immigrants still face challenges with acculturation, cross-cultural conflicts, communication, and language barriers; therefore, access to mental health services remains disproportionately low, especially in San Joaquin County. While past researchers have explored other aspects of Cambodian immigrants' experiences in the United States such as cultural and economic statuses, health, behavioral health, and other social concerns have not received comparable attention, particularly issues relating to PTSD.

Despite the increased incidence and prevalence of PTSD among Cambodian immigrants, military personnel, and the general population, cultural beliefs and stigma about the illness may contribute to reticence in seeking mental health services, which can result in missed opportunities for mental health assessment and proper diagnosis (Davy & Ehiobuche, 2013). Many Cambodian men and women suffering from PTSD do not receive support or treatment because of a lack of knowledge and stigma from a cultural background where PTSD is not part of the cultural knowledge or understanding. According to Marshall et al. (2005), the prevalence rate for PTSD in Cambodian men and women is 62%. In addition to this high prevalence rate, members of the Cambodian immigrant community often experience more than one type of PTSD symptom due to the different traumas experienced during the war, genocide, and refugee camps (Kiernan,

2013; Marshal et al., 2005). PTSD should be diagnosed appropriately and treated effectively. Not addressing this mental health issue might be detrimental to the physical, emotional, and social wellbeing of the individual, family, and community (Beck, 2006; Davy & Ehiobuche, 2013).

Problem Statement

Cambodian immigrants are one of the largest Southeast Asian ethnic groups in Stockton, California. While the prevalence of and symptoms associated with PTSD are well understood for the general population and veterans, many primary care and mental health providers do not yet fully understand how PTSD is manifested among Cambodian-American men and women. Despite the seriousness of PTSD and its effect on physical, emotional, and social factors, Cambodian immigrants might be experiencing this phenomenon without sufficient knowledge of how to identify or manage it (Davy & Ehiobuche, 2013; Wong et al., 2006). Hence, research is needed to increase researchers' and mental health care workers' knowledge of how PTSD is manifested and addressed in Cambodian immigrants to assist them in accessing mental health services, understand the motivation that will help them get help when needed, and develop strategies that are culturally appropriate and effective in identifying and treating PTSD among culturally diverse communities.

Purpose of the Study

The purpose of this study was to explore Cambodian immigrants' cultural interpretations of PTSD in Stockton, California. In this qualitative study, I investigated participants' perceptions of how PTSD is manifested in this community in order to

understand the barriers to accessing mental health services by the Cambodian immigrant community.

Theoretical Framework

Bronfenbrenner's social ecological model (SEM) of human development guided the theoretical framework of this research (Bronfenbrenner, 1979). The social ecological theory provides a platform for comprehensively examining the roles of culture and language in health- and mental-health-related issues. This theoretical model emerged from various disciplines, including anthropology, psychology, and sociology, thus permitting broader insight into individuals' cultural, social, behavioral, and environmental structures (Bronfenbrenner, 1979). Given the various unknown environmental, cultural, traditional, and spiritual factors that may affect how a community perceives mental health issues, it is imperative to explore individuals' experiences from various perspectives. This theoretical framework provided me a broader perspective for comprehending the mental health-related issue concerning individual men and women from the Cambodian community. In addition, this framework allowed for an in-depth understanding of how culture, traditions, values, and beliefs affect how the Cambodian immigrants perceive PTSD and the mental health system.

Nature of the Study

I employed a phenomenological qualitative approach for data gathering to investigate how PTSD is perceived by Cambodian immigrants in Stockton, California. This approach involved using in-depth semi structured interviews to (a) determine participants' knowledge and understanding of PTSD, (b) assess their healing practices

and coping skills, and (c) assess their knowledge and understand of when and how to access mental health services. The study may provide a better understanding of the indicators that would motivate Cambodian immigrants to access mental health services.

Research Questions

The following questions guided the study and formed the primary basis for data collection. I also used additional follow up interview questions.

1. How much knowledge do Cambodian immigrants in Stockton know about PTSD?
2. What are some cultural healing practices and coping skills used for helping Cambodian immigrants in Stockton who have PTSD?
3. What knowledge do Cambodian immigrants have about mental/behavioral health resources in San Joaquin County and do they know how and where to access the resources?

Assumptions

I made several assumptions in this study. It may be that Cambodian immigrants do not have an understanding of PTSD because the mental health system in Cambodia does not include awareness of PTSD. The interpretation of PTSD by Cambodian immigrant community relates to the social, cultural, and religious beliefs shared among the Cambodian immigrant community. In this community, knowledge of how to access mental health services in the United States is limited. Moreover, in this study I assumed that participants would answer questions honestly and openly, albeit with hesitation.

Limitations

The transferability of this study's findings may be affected by several limitations. The first limitation of this study concerns my use of face-to-face interviews as the main source of data with Cambodian immigrants. Recruiting older members of the Cambodian community who are fluent in English was difficult because many older Cambodian immigrants are not fluent in the English language. In addition, when asking questions to older Cambodians, I had to be aware of cultural norms and hierarchy. To mitigate this limitation, I established a level of trust, rapport, and demonstrated my cultural awareness of hierarchy of respect with the participants to build a deeper understanding of their knowledge and experiences (see Boonpleng et al., 2013).

Further limitations of the study were associated with the cultural-linguistic barriers relating to mental health terminology. Difficulties with language and terminology may have been factors that exacerbated the problem addressed in this study, because it is difficult to explain certain behavioral and psychological terminology in the Khmer language because some English terminologies do not translate well into Khmer (Thlang, 2011). In addition, this study is limited to Cambodian immigrants in Stockton, California, and is not representative of other Cambodian immigrant communities in other parts of the United States.

Delimitations

This study was delimited by age and geographic criteria. Participants were 18 years or older, resided in Stockton, California, and had family member(s) who lived through the Cambodian genocide or the refugee camp. I chose participants with different

educational levels, including elementary and high school, some college, 2- through 4-year college degree, and English speaking (to complete the demographic questionnaire).

Definition of Terms

I have used a variety of terms when addressing the targeted participants, references to language, and other correlating factors. The following is a list of definitions for key terms is used throughout this research.

Acculturation: "The process of cultural change and psychological change that results following meetings between cultures. The effect of acculturation can be observed in multiple levels in which a new group of community members learns, adjusts to, and internalizes a new culture" (Berry, 2004, p. 168).

Assimilation: The process by which a minority group gradually adapts to the customs and attitudes of the general culture. Learning how to speak to the language of the new environment is one example (James, 2004, p. 43).

Cambodians: Members of a group of ethnic minorities from Cambodia, located in Southeast Asia (Chhim, 2003).

Cambodian-Americans: Individuals who are Americans born or raised in (or descended from those born or raised in) Cambodia, who are of Khmer descent (Chhim, 2003).

Cambodian immigrant community: The target population of this study included both men and women who were born in Cambodia or the refugee camp who migrated from Cambodia. (Chhim, 2013).

Co-morbidity: "When two disorders or illnesses occur in the same person,

simultaneously or sequentially" (Division of Adult and Community Health, Centers for Disease Control and Prevention, 2011).

Culture: "A way of life of a group of people; the generally accepted behavior, beliefs, values, and symbols which are held in common within and among that particular group, generally without deliberation, and which are generationally passed along by way of communication and imitation from one generation to the next" (Betancourt, Green, & Carrillo, 2003, p. 295).

Cultural competence: "A type of organizational framework which aims to establish culture-specific understanding among members of a certain profession or field, particularly when dealing with diverse cultural groups with a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enable such a system, agency, or a profession to work effectively in cross-cultural situations" (Betancourt et al., 2003, p. 296).

Genocide: The deliberate killing of a large group of people to destroy their ethnicity (Office of the UN Special Advisor on the Prevention of Genocide [OSAPG], 2016).

Immigrant: A person who enters a different country with the intent to establish permanent residency, but has citizenship of another country (OSAPG, 2016).

PTSD (Post-traumatic stress disorder): A mental health problem that can occur after a traumatic event. Such events include assault, abuse, neglect, natural disaster, or other catastrophes (National Center for PTSD, 2013).

Refugee: A person who fled his or her home country to escape war, persecution,

genocide, famine, epidemic disease, or natural disaster (OSAPG, 2016).

Social Significance

PTSD affects more than 62% of Cambodian adults in the United States (Marshall et al., 2005). Untreated mental health symptoms experienced by any member of the family tend to affect the dynamics of the family unit, and likely contribute to other chronic and adverse health problems (Friedman, 2013). There is a relationship between cultural beliefs, stigma, knowledge, attitudes, and behavior that researchers have found affects awareness, early detection, healing practices, and coping skills for PTSD among Cambodian immigrants (Collins, Zimmerman, & Howard, 2011). By and large, Cambodian immigrants seem to be unaware of or do not understand the mental health resources and other related services that are available in their communities, and this is largely attributed to barriers related to culture and language (Collins et al., 2011).

As a member of the Cambodian community, I have met others from the community who have shared intimate stories of struggles and feelings of hopelessness related to mental illness. Nevertheless, many of them choose not to seek help or to access available resources. I understand this phenomenon on a very personal level; my mother silently suffered from PTSD and depression for over 30 years before she agreed to seek appropriate help. It is imperative to increase access to PTSD support and related services, and to properly disseminate information regarding mental health and wellness to improve the knowledge and understanding of PTSD within the Cambodian community. In doing so, we may reduce the stigma that is commonly attached to this condition, eliminate known barriers and bridge the gaps in services, and make additional changes that are

culturally appropriate and effective. This study has the potential to advance knowledge of PTSD in the Cambodian immigrant community as well as other immigrant communities who have similar historical trauma due to war and displacement. A deeper understanding and awareness as to how the Cambodian community understands and interprets PTSD will motivate behavioral health agencies to use culturally appropriate approaches in the outreach efforts, and will potentially bring about effective culturally-responsive mental health services.

There are many areas where positive social change may take place as a result of findings from this study. One of my goals for this study was for it to serve as a catalyst for progressive change within the Cambodian immigrant community by expanding general awareness and increasing the collective knowledge base of the community with respect to the subject of PTSD. This outcome would likely improve the capacity of family members and friends to identify symptoms and be informed as to common facts, such as how, when, and where to access mental health services and relevant resources that are available in the community. Furthermore, I anticipate that findings from this study will operate as helpful guideposts to assist behavioral health administrators, program developers, and direct providers in developing culturally responsive trainings that will be more likely to meet the complex needs of the diverse communities in Stockton, California, than the methods and approaches presently employed. Most importantly, individuals who are now suffering, or may be vulnerable to suffering, from PTSD would have a greater opportunity for, and likelihood to, access appropriate help so that they would be more likely to live full, productive, and quality lives with newfound

hope and healing.

Summary and Transition

In this chapter, I introduced PTSD among Cambodian immigrants as a mental health and public health issue. The seriousness and high prevalence rate of PTSD in the Cambodian immigrant community needs to be identified, understood, and addressed by the community and providers to increase access to mental health services and outreach efforts to prevent adverse health outcomes. The purpose of this phenomenological study was to investigate and facilitate understanding of the cultural and sociohistorical complexities that contribute to PTSD and barriers to accessing mental health services within the Cambodian immigrant community. Chapter 2 includes a review of the literature related to PTSD and the theoretical model that explains PTSD in the target population.

Chapter 2: Review of the Literature

Introduction

The purpose of this study was to explore Cambodian immigrants' cultural understanding and interpretation of PTSD in Stockton, California. The purpose of this literature review is to analyze the topic of PTSD. This review helps frame my study by including empirical peer-reviewed literature and theoretical studies to define PTSD and its manifestation among Cambodian immigrants. In addition, I applied research methodologies that are related to the Cambodian immigrant community and mental health issues. The SEM served as a foundation to compare the historical traumas as well as the sociological, cultural, religious, and social factors that prevent Cambodian immigrants from accessing mental health services to address PTSD.

I gathered materials for the literature review on PTSD among Cambodian immigrants using databases such as EBSCO host, PsycINFO, PsycARTICLES, Nursing Academic Edition, Google Scholar, National Alliance for Mental Illness (NAMI), the *Journal of the American Medical Association* (JAMA), Society and Mental Health (SMH), the Centers for Disease Control and Prevention (CDC), and the National Institute for Mental Health (NIMH). I limited the database searches to scholarly materials published from 2005 through 2015. Due to the limited research on this target population, I used this longer 10-year span to search the relevant literature. The following keywords and phrases were used to conduct the searches : *culture, race, ethnicity, mental health, historical trauma, post-traumatic stress disorder, impact of post-traumatic stress disorder among Cambodian immigrants, mental health among Cambodian immigrants,*

war and trauma among Cambodian immigrants, Cambodian immigrants in Stockton, California, post-traumatic stress disorder statistics within America, barriers to accessing mental health services among Cambodian immigrants, and *mental health healing practices among Cambodian immigrants.*

Historical and Sociocultural Factors Related to PTSD

Historical and sociocultural factors indicate that, as a group, Cambodian immigrants are in desire need of mental health services that are culturally and linguistically (Marshall et al., 2005). Cambodian immigrants, on average, have a relatively low educational and economic status (Center for American Progress, 2015). The need for mental health services is high given the trauma experienced during the war and genocide of the 1970s (Marshall et al., 2005). To understand the contributing factors that lead to the disproportionately high rates of PTSD, a basic awareness of Cambodia's history of war and genocide is essential.

Post-Traumatic Stress Disorder and Public Health

PTSD is a public health concern. Previously, PTSD had been classified as one of the subcategories of anxiety disorder in the *DSM-5* (APA, 2013). Recently, the *DSM-5* authors have modified the guide's past classification rubric in its current version; consequently, trauma and stress disorder are included in the category of PTSD (Friedman, 2013). The traumatic event (or series of events) plays (or play) a critical role in both the environmental and social factors which may affect an individual either directly or indirectly, thereby establishing the emotional seed for later triggering of PTSD symptoms (Friedman, 2013). To meet the current criteria for a diagnosis of PTSD, an

individual must exhibit symptoms from the following three clusters: (a) alteration in arousal and reactivity, (b) persistent re-experiencing, (c) and responding in an avoidant and numbing manner (APA, 2013). The root experience must be stress- or trauma-related, and not a product of medication, substance abuse, or physical illness (APA, 2013). According to the current data from NAMI, the prevalence rate of PTSD among men in the United States is 5%, and the prevalence rate for women in the United States is 10%. The lifetime prevalence rate is 8% regardless of gender (NAMI, 2013). The prevalence of PTSD is on the rise in the United States as result of the recent wars in the Middle East and the influx of refugees (Iribarren, Prolo, Neagos, & Chiappelli, 2005).

Despite the increased incidence and prevalence of PTSD among military personnel and the general population, the rate of the two populations combined is still less than the prevalence rate of PTSD among Cambodian immigrants (Marshal et al., 2005). According to Marshall et al. (2005), the prevalence rate for PTSD is 62% for Cambodian men and women. In addition to the high prevalence rate, Cambodian immigrants experience more than one type of PTSD symptom due to the diversity of trauma experienced during the war, genocide, and refugee camps (Kiernan, 2012; Marshal et al., 2005). The initial PTSD symptoms include reliving the event through nightmares and flashbacks. Sometimes, smells, sights, or sounds might trigger flashbacks. Over 50% of first-generation Cambodian immigrants experience this type of symptom due to their exposure (Marshall et al., 2005). A second characteristic experienced by individuals living with PTSD is avoidance of situations that reminds them of the traumatic event. Individuals experiencing this type of symptom usually avoid

talking or even thinking about the traumatic event to prevent memories from surfacing (National Center for PTSD, 2013). The third type of symptom is characterized by how the individuals think and feel about themselves, others, and the world around them. For example, victims of physical or sexual assaults may stay away from relationships, think the world is dangerous, and have difficulty trusting others (National Center for PTSD, 2013). The fourth type of symptom is hyperarousal, characterized by constant fear, alertness for danger, surprises or loud noises as well as being easily startled, having difficulty sleeping and concentrating, and being prone to sudden anger or irritability (National Center for PTSD, 2013).

There is a need to address the cultural, traditional, and religious views of mental illness among the growing population of immigrants in the United States, particularly the Cambodian population, which, with a growth of 55%, is growing more rapidly than the U.S. population as a whole (Castleman, 2011; Center for the American Progress, 2015). Cambodian immigrants and descendants in the United States continue to experience challenges relating to acculturation, poverty, health, and mental health (Marshall et al., 2005). More than 37% of Cambodian immigrants do not have a high school diploma, 81% speak a language other than English at home, and more than 25% do not have health insurance (Castleman, 2011; Center for the American Progress, 2015). The growing challenges due to population growth contribute to the increasing need of culturally responsive mental health services (Marshall et al., 2005).

Relevance of Theoretical Model to PTSD

In this study, Bronfenbrenner's (1979) SEM provides a comprehensive

perspective I used to demonstrate and understand the connection between PTSD and Cambodian immigrants. The health belief model (HBM) by social psychologists Hochbaum, Rosenstock, and Kegels, which focuses on the beliefs and attitude of individuals, was also applicable (Connor & Norman, 1996); however, the SEM provide a better approach for explaining behavioral change and the social environmental. The SEM is a "set of theoretical foundation[s]" that can serve as foundation for the social ecological approach to health promotion (Stokols, 1996, p. 262). This model helped in my investigation how historical, social, cultural, religious, spiritual, and family structure trauma might contribute to barriers in accessing mental health services to address PTSD among Cambodian immigrants. Moreover, they may be experiencing stressful living conditions in addition to their past trauma, contributing to an increased risk for PTSD (Kiernan, 2012). Therefore, to support and encourage these individuals in accessing mental health services, it is imperative to address the historical background, social practices, environmental factors, spiritual beliefs, and cultural limitations that foster the interconnections among the microsystems, macrosystems, and chronosystems within an individual's social ecological structure.

The Microsystem

The microsystem is the primary setting of personal life where the individual has close, direct, and regular interactions (Santrock, 2011). The microsystem has unique qualities in the development of individuals. The microsystem is a factor that has the greatest influence on the individual in a bi-directional level (Santrock, 2011). The microsystem involves the immediate surroundings where the individual has relationships

and interactions such as those involving family, neighborhood, school, church, and work environments (Berk, 2000). The Cambodian immigrant community in Stockton, California, lives in neighborhoods called *villages*. The interpersonal relationships among the community members are deeply rooted in shared experience of war, cultural beliefs, healing practices, and shared experiences of acculturation within the microsystem.

The Macrosystem

The macrosystem is "composed of cultural values, customs, and laws" that serve as the "societal blueprint for a given culture, society, or subgroup within a larger society" (Abrahamson, 1996, p. 188; Berk, 2000). The macrosystem is the overall pattern of ideology and organization that characterizes a given society, including attitudes, values, and beliefs commonly shared by societal groups (Abrahamson, 1996). The Cambodian immigrant community is a subsystem that shares specific cultural values, customs, and beliefs, but still has influence from the mainstream social norms (Abrahamson, 1996). The macrosystem plays an important role in keeping the fabric of society together through shared cultural values and beliefs (Berk, 2000). This system can be observed within the Cambodian immigrant community through the way information is passed on, the practice and information sharing relating to sets of traditional and spiritual beliefs regarding mental illness, and hesitation among people of the Cambodian immigrant community to access mental health services (Kiernan, 2012; Marshall et al., 2005).

The Chronosystem

The chronosystem represents the environment, events, and transitions that occur in a person's life and sociohistorical circumstances (Abrahamson, 1996). This system

connects the microsystem with the macrosystem, and includes health status, family structure, socioeconomic status, place of residence, and life circumstances (Sanstrock, 2011). The Cambodian immigrant community experienced sociohistorical circumstances that resulted in a significant shift in life transition (Kiernan, 2012). The social cultural patterns in the Cambodian immigrant community change in order to acculturate to the larger system; however, the community still strives to hold on to its ethnic identity, cultural values, traditions, and healing practices (Kiernan, 2012). For this reason, in order to be successful in reaching out to this community, health-care professionals should understand the relationship and interconnection of all three systems.

Family and Social Structure

Family and social structure is the microsystem that closely and directly affects a person's perception and understanding of the world at an early age (Sanstrock, 2011). Kramer, Kwon, Lee, and Chung (2002) examined cultural factors that influenced overall mental health among Asian Americans, especially among those most affected because they shared, as a unique group, experiences that contributed to the greatest barriers in accessing mental health services. Kramer et al. (2002) found that culturally relevant factors such as gender, age, traditional values, family structure, shared societal norms, and social stigma were often fundamental factors in preventing Asian immigrants, including Cambodian immigrants, from seeking mental health services (Kramer et al., 2002). Socially, Cambodian immigrants consider mental illness a private family matter (Marshall et al., 2005). Seeking help from the mental health system is perceived as putting the family business in the open, displaying a lack of competency in caring for a

loved one (Kramer et al., 2002).

Cambodian immigrants have a close-knit family structure, characterized by family name and reputation (Kramer et al., 2002). Cambodian culture largely shares similar emphasis and importance upon the way one fulfills one's obligation to carry the family name (Kramer et al., 2002). Outward appearance and general reputation among the local community carry great weight and may sometimes supersede the individual needs of one member of the family unit, even one with mental health needs, to which stigma commonly attaches (Kiernan, 2012). Therefore, when a family member has a problem, the problem not only affects that individual, but all members of the family and ancestors of the individual, possibly tarnishing the good name and reputation of the family (Kramer et al., 2002). This type of prejudicial treatment is one likely reason for the hesitation of seeking mental health services (Kiernan, 2012). Another likely reason is that Cambodian immigrants, like many Asian immigrants, have limited knowledge and understanding of mental illness, especially the concept of PTSD (Chung, 2010).

Kohrt and Harper (2008) studied the limited knowledge and understanding of mental illness among the Nepalese, including how mental illness contributed to the stigma attached to the afflicted person. According to their study, when someone in the community was known to have a mental illness, people from the community would avoid associating with the individual and his or her family; the entire family would essentially be shunned (Kohrt & Harper, 2008). Mental health stigma throughout the Cambodian community is similar. Mental illness such as PTSD in a family can bring shame and dishonor to the family's name (Chung, 2010).

Frye and McGill (1993) discussed the challenges in mental health nursing because of the differences in perception, culture, and tradition among Cambodian immigrants. In addition to protecting the family's name, the Cambodian culture also has different views on the care of loved ones. Traditionally, when a family member is ill, despite the illness, the family sees it as their responsibility to care for their family members at home, without consulting with or seeking interventions from outsiders (Frye & McGill, 1993). Monks or shamans, among the most respected and honored spiritual healers in the Cambodian community, are the only outsiders the family would consider asking for help (Catolico, 2013). Due to the lack of knowledge, understanding of root causes of PTSD and other mental illness, and fear of social rejection, many families among the Cambodian immigrant community would keep this matter a family secret (Kramer et al., 2002).

Gender Perspective

Gender plays a significant role in accessing mental health services among Cambodian immigrants. Traditionally, Cambodian culture has been viewed as patriarchal. Men were heads of the households and maintained full decision-making authority (Kramer et al., 2002). During the genocide, however, half the men were killed, leaving many women solely responsible for the care and support of remaining family members (Seanglim, 1991). After arriving in the United States, many of the surviving Cambodian women suffered trauma, loss, and socioeconomic challenges, and even those not separated from spouses or physical family experienced harm (Peou, 2013). Catolico (2013) found that female caretakers headed and supported 30.1% of Cambodian households in California. As the head of the household, the women hold the status and

honor for the entire family (Nissay, personal interview, 2015). Catolico (2013) found that Cambodian women residing within the state of California had a poverty rate of 38.8%. The high poverty rate among female Cambodian immigrants is likely because of language barriers, lack of education, and difficulty finding stable employment (Marshall et al., 2005). These factors increase existing vulnerabilities and further isolate this population, thereby adding to the obstacles and inability encountered in accessing mental health services (Marshall et al., 2005).

While male Cambodian immigrants also have suffered from PTSD, according to Marshall et al. (2005), the prevalence rate is much lower than the rate among female. Traditionally, Cambodian men are not taught to express feelings or to show any signs of emotional or mental vulnerability (Kramer et al., 2002). Because of this cultural mandate, Cambodian men often mask their troubles behind other negative behaviors such excessive drinking or similarly unhealthy behavior (Hinton, Hinton, Eng, & Choung, 2012).

In comparison to Cambodian women, Cambodian men have also experienced challenges after their arrival in the United States. Most Cambodian immigrants who survived the genocide in Cambodia were farmers prior to the beginning of the atrocities (Kramer et al., 2002). Many Cambodian immigrants were resettled into cities upon their arrival to the United States and were thus unable to support their families in the United States, at least not within the urban environments where most had been resettled (Seanglim, 1991). The lack of work, language barrier, poverty, and changes in gender-based roles and responsibilities among male Cambodian immigrants in the United States

contributed further to a sense of worthlessness, helplessness, and shame. These could be factors in the currently high rates of domestic violence and substance use among Cambodian men in the United States, in addition to the high rate of PTSD (Castleman, 2011; Marshall et al., 2005).

Religion, Spirituality, and Healing Practices

Another cultural factor that may prevent both men and women of the Cambodian immigrant community from accessing mental health services, according to Catolico (2013), is traditional, spiritual, and religious beliefs. Pargament (2013) found that religion and spirituality are often significant barriers preventing people from seeking mental health services. Historically, integrating faith, religion, and spirituality into the treatment of mental illness has been controversial (Devon, Pich, Cheean, & Pollack, 2005). However, many people turn to faith and spirituality for support during major life stressors (Pargament, 2013). In the Cambodian culture, beliefs, tradition, and overall way of life, Buddhism plays a significant role (Berkman, 2006, p. 208). Buddhist teaching consists largely of the Four Noble Truths, which focus on suffering. To live, humans must experience suffering—physical, emotional, mental, or other suffering (Buddha Dharma Education Association, 2015).

For many Cambodians, losing loved ones and the pain endured during the genocide would be considered part of suffering, called *kum* (Berkman, 2006, p. 208). Nightmares, fear, nervousness, emotional pain, and hopelessness involve emotional suffering (Devon et al., 2005). To relieve oneself of the pain, one must pray to the spirits of one's dead relatives to set the relatives' souls free (Buddha Dharma Education

Association, 2015). It is believed that when the souls of the dead relatives are free, the surviving family members can be freed from the same suffering (Devon et al., 2005). Suffering from PTSD is often a sign that a person's past and the spirit of the dead relatives are still trapped in the spirit world (Buddha Dharma Education Association, 2015). One must accept this suffering as part of spiritual learning and must participate in the spiritual practice to free the spirits of dead relatives (Buddha Dharma Education Association, 2015). Prayer then can free the individual from suffering (Buddha Dharma Education Association, 2015).

The meditation practices of Theravada Buddhism focus on mindfulness. When meditating, family members believe that they can heal, protect, feed, and guide their deceased relatives in the afterlife (Holt, 2012; Kent, 2006). Such belief is one reasons why many survivors of the Cambodian genocide attend prayer functions at the Buddhist temple and have prayer altars in their homes (Ladwig, 2012). In addition to the belief in the spirit world, Cambodians also believe in possession of soul and body by evil spirits or ghosts (Ladwig, 2012). It is believed that when evil spirit or a ghost appears to possess a person, the person may behave abnormally (Holt, 2012). Hence, Cambodians may perceive the behaviors of someone suffering from PTSD as evil spirit possession rather than as mental illness (Kramer et al., 2002).

Religious beliefs and healing practices work together. To heal the "possessed" individual, family members take the person to the healer or invite the healer to their house to perform an exorcism-like ritual (Betty, 2005). During the ritual to exorcise the evil spirit or ghost, the healer burns incense and candles, chews on betel leaves to create a

caustic pink paste, and chants sacred words while blowing on the "possessed" person's face and sprinkling holy water on the person's head (Kent, 2006). Because of cultural beliefs and practices, many Cambodians in Cambodia and Cambodian immigrants in the United States would seek spiritual healers and monks first before seeking help from anyone in the medical or behavioral health community (Kent, 2006).

Social Perspective

Besides the cultural and spiritual beliefs, members from the Cambodian immigrant community are afraid to seek help from the mental health professional because of social stigma and discrimination attached to mental illness, affecting individuals and their families (NAMI, 2013; Weiss, Ramakrishna, & Somma, 2006). As reported in the 2012 Cambodian Mental Health Report, because of the public shame, blame, and discrimination related to stigma, some family members have locked up or chained the mentally ill person at home to avoid public humiliation. According to Kohrt and Harper (2008), the stigma of mental illness also prevents other relatives of the mentally ill person from marrying or from associating freely with others because of the idea that mental illness is contagious. This same stigma is present for Cambodian immigrant communities living in the United States as well (Kent, 2006). To "save face," a myth is often used to blame the signs and symptoms of such conditions on psychotropic medications (C. Sap, personal communication, March 12, 2015). Because of this socially shared misconception, that psychotropic medication worsens the signs and symptoms, those who experience the symptoms are afraid to inform others or to access services (Kohrt &

Harper, 2008).

Access to mental health services to address PTSD is a challenging process among Cambodian immigrants. As explained in prior sections, the interconnectedness of the microsystem, macrosystem, and chronosystem within the socioecological model among Cambodian immigrants is deep rooted. Despite the high prevalence of PTSD among the Cambodian immigrant community, this illness remains misunderstood. If social practices, spiritual and religious beliefs, and cultural limitations continue as a hindrance to accurately perceiving PTSD as an illness, such challenges to treating the condition will continue. However, based on the ecological model of health behavior, with comprehensive interventions, policy makers and providers can systemically target the mechanism of change at each level (Sallis, Owen, & Fisher, 2008). This approach can be successful when providers and policy makers identify the barriers at each of the different levels of influence.

Qualitative Research Concept and Rationale for Using Qualitative Methodology

In exploring complex issues, qualitative research can deliver outcomes of human feelings and emotions that quantitative research cannot achieve (Cohen & Manion, 2004). Creswell (2003) stated that the use of qualitative research enhanced the understanding and the methodological traditions of inquiry allows researchers to investigate human interaction or social phenomenon. Qualitative research provides opportunities for researchers to present case studies, conduct personal interviews, share historical background, and share observations (Bryan, 1988). Qualitative research also provides participants the opportunity to share personal experience and life stories (Bryan, 1988). In

addition, qualitative research is “highly effective in providing complex descriptions of individual experiences” (Mack, Woodsong, Macqueen, Guest, & Namey, 2005, pp. 1-5).

Qualitative research was utilized for this study to collect and analyze data, as well as to answer the research questions. This methodology provided an understanding of the complex issues of PTSD among Cambodian immigrants in relation to the social practices, spiritual and religious beliefs, family structure, and cultural limitations. The advantages of using a qualitative design in this research study is the flexibility of asking open-ended questions to evoke responses that are meaningful, thorough, and culturally appropriate to the participants, and the opportunity for comprehensive responses (Creswell, 2007). Marshall et al. (2005) suggested using a qualitative research approach to explore the barriers to access to mental health among Cambodian immigrants because qualitative research gives researchers an opportunity to clarify questions and ask follow-up questions to gain a better understanding of a problem. In addition, due to the cultural, historical, and social factors of the participants, qualitative research allows researchers the opportunity to establish trust and rapport through personal interactions to obtain accurate information during the interviews (Creswell, 2003).

Summary and Transition

This chapter included the different cultural, spiritual, religious, and social factors that might contribute to the barriers and/or motivators to accessing mental health services among Cambodian immigrants. This exploration was an attempt to support the understanding of the interconnectedness of different layers within the social ecological model that influence an individual’s behavior and perception about PTSD. In addition,

this chapter provided the historical and social factors that affect the Cambodian immigrants in the United States. The historical context provides an understanding of the root cause of the high rate of PTSD among Cambodian immigrants.

Chapter 3 will include detailed information about the research methodology to be used to explore the research gap identified in Chapter 2.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to investigate the cultural understanding and interpretation of PTSD among Cambodian immigrants in Stockton, California. In this qualitative study, I explored the participants' perceptions of how PTSD is manifested in this community to understand barriers to accessing mental health services. This chapter provides an overview of the study, a definition of the population for this dissertation, the criteria I used for selecting and including participants in the study, and explanations of the research methodology, study design, data collection procedures, and ethical issues associated with the research process.

Research Design and Approach

I used a qualitative case study design. A qualitative case study is a comprehensive approach to explore a particular problem (Creswell, 2003, p. 96). This approach was most appropriate for this study because the design allows for an in-depth investigation and understanding of the population (Kohlbacher, 2005). This approach also allows participants an opportunity to express the complexity of the issues in their own words while, at the same time, giving the interviewer the opportunity to follow up with additional questions to better understand the issues being explored (Creswell, 2003; Trochim & Donnelly, 2007). In this study, I combined the case study design with a phenomenological approach to explore individuals' understanding, beliefs, and experiences of PTSD.

For data collection, I used semi structured, face-to-face interviews with the participants. In qualitative research, interviews are the most frequently used data collection method (Creswell, 2003). Qualitative interviews involve semi structured, open-ended questions (Kohlbacher, 2005). The face-to-face interview method is valuable for helping to establish trust and rapport with the participants, especially when attempting to obtain culturally sensitive information (Berg, 1998).

I conducted this study in four phases. The first phase included a focus group, which included getting the participants to consent to the study, refining interview questions, and conducting the face-to-face interviews for data collection. The second phase of this study was the recruitment phase. The third phase was data processing and analysis. The final phase was discussion of the findings.

Setting and Sample Selection

The community of interest for this study was Cambodian immigrants who reside in Stockton, California, home to the third-largest Cambodian immigrant population in the United States (Applied Survey Research, 2008). To participate in this study, the participants must have met the following criteria: born in Cambodia, be 18 years and older, and have family member(s) who lived through the Cambodian genocide and/or refugee camps. Participants were encouraged to speak either English or their native language. I recruited participants for this study by distributing flyers (Appendix A) in locations where members of the Cambodian community reside, creating an event-recruiting page on social media, and distributing the flyers to local Asian markets where the community members shop and at the local Cambodian temples. I also offered

incentive to increase the recruitment success rate.

The flyers included the purpose of the study, my interest in the topic of understanding how PTSD is perceived among the Cambodian immigrants, and an invitation to interested individuals to contact me. The recruitment period continued until enough participants were recruited. Once the number of recruits met the required number of participants for the study, recruitment stopped. I contacted the interested individuals to conduct a brief initial screening to determine their eligibility to participate in the study. The sample was not necessarily intended to be representative of the Cambodian immigrant community since the recruitment was dependent on who was available and willing to participate in the study. I recruited and screened 13 participants. The 13 participants were carefully screened to meet the criteria for being 18 years and older, born in Cambodian, and personally knew someone who had lived through the genocide and/or the refugee camp.

Instrumentation and Materials

The questionnaire consisted of semi structured, open-ended questions designed to collect demographic data and to determine the understanding of PTSD among the Cambodian immigrant community. I recruited 2 individuals from the Cambodian immigrant community to participate in a pilot study to establish validity and reliability of the questionnaire. The pilot study group met at the local Cambodian temple, which was convenient and easily accessible. The actual interviews were held at San Joaquin Delta College library because it was inviting and secure. The purpose of the pilot study was to pre-test the interview questions for validity and reliability to see if the interview

questions were appropriate for the one-on-one interviews, and to see if the language or words used for the questions were appropriate to draw out information (see Creswell, 2009). The pilot study group was a stratified group, consisting of a man and a woman who are 18 years of age and older and have family members who lived through the genocide and refugee camps. Because of the sensitivity of the topic, finding an environment that is safe, comfortable, and non-judgmental for the participants was crucial (see Powel et al., 1996). The local Cambodian temple offered a comfortable atmosphere, and I provided food to participants. The participants for the pilot study were videotaped so I could go back and capture information that I might have missed in the pilot study group discussion.

Data Collection

Recruitment Phase

In the recruitment phase, I distributed the flyers in locations where the Cambodian immigrant communities are most accessible. In this phase, I informed potential participants of the study as well as contacted community leaders to assist in the recruitment of the participants. I also asked the participants questions to ensure that the participants meet the eligibility criteria and explained to the participants the step-by-step process of what was to take place in the semi structured and how this study could benefit the community. In addition, I provided and thoroughly discussed the purpose of the informed consent form. Each participant who met the criteria was required to sign an informed consent form prior to the start of the study.

Interviews

Based on the age, historical contexts, and lived experiences of the participants, I was especially cautious and sensitive when discussing PTSD. It is important to be mindful of the sensitive nature of the interaction, and to understand that this is an opportunity to develop trust and rapport with the participants. Semi structured, open-ended interviews provided great insight into the socio-cultural factors that contribute to the understanding and perception of PTSD among Cambodian immigrant communities (Creswell, 2003).

By conducting semi structured, open-ended interviews, I was able to listen to the participants' experiences and perceptions. One advantage in conducting the semi structured, open-ended interviews was that I could speak the language, and my background is similar to many of the participants. This likely allowed the participants to express themselves without fear of being misunderstood. The interviews were recorded using an audio recorder. I initially planned on videotaping the interviews; however, participants declined the videotaping, therefore, I used audiotaping. My rationale for wanting to videotape the participants was to emphasize the importance of non-verbal communication in the Cambodian community. Body language and facial expressions are crucial in understanding the hidden meaning behind unspoken words (Thlang, 2007). I used audiotape to capture the questions and answers and write down my observations of body language to the side of the answers to each question. Once the interviews were completed, the next step in the process was data analysis.

Data Analysis

I reviewed the audio recorded interviews. I then transcribed the information from the recorder onto paper and then reviewed the transcriptions for themes. Themes found within the interviews were tracked for codes. After the data analysis was complete, I stored all records, including the research materials, in a locked file cabinet.

I then tabulated and analyzed the completed interviews using thematic analysis software (NVivo). Thematic analysis was most appropriate for this study because it allowed me to pinpoint themes and patterns from the surveys (see Braun & Clarke, 2006). Thematic analysis provides descriptions of the phenomenon and answers to the research questions (Braun & Clarke, 2006). I identified and defined themes by using a coding method to dissect different information elements from the interviews to capture the elements related to the research topic (see Charmaz, 2006). Coding is a process for defining, describing, and linking the data to the topic under study (Charmaz, 2006). The coding was facilitated by entering the interview transcripts into NVivo. If the questions and answers had mixtures of English and Cambodian, I translated them to all English first, and then transcribe them. I used NVivo, a software program used in qualitative studies to assist with organizing the codes into themes (Davison, 2008). After the coding was finished, the themes were categorized, and the results were printed for further analysis and stored in a flash drive for record keeping. Following analyses of all data, I summarized and reviewed the findings. In Chapter 4, I discuss the results of my analysis.

Measure of Ethical Protection for Participants

Ethical consideration and protection of human rights received the highest priority

in this research study. This approach is in accordance with the ethical standards required when interacting directly with human beings in social research, especially in cases that involve vulnerable populations as in the currently proposed study (Creswell, 2003). I received IRB approval # 06-29-17-0130242 for this research project before beginning data collection.

In the study invitation, I clearly stated the purpose of this study along with the objectives and potential risks and benefits. Prior to obtaining consent from participants in this study, I reiterated that this research was voluntary and the participants could withdraw from the study at any time in the research process and for any reason. I explained the importance of confidentiality and ensured that the participants felt comfortable and safe in the interviews.

In addition, I safeguarded participants' demographic information and ensured that their names and addresses were neither shared nor identifiable. Information and collected data was kept safe at all times and secured within a locked container. Throughout out study, I referred to participants using their actual first name, in alphabetical order. Following completion of all data acquisition and analysis, and after completion of this dissertation, I have kept all personal and private data in accordance with established guidelines governing such practices. Specifically, I have stored the data, which I will keep for 5 years, in a locked file cabinet.

Role of the Researcher

As a researcher, I understood my role and responsibilities for this study. First, I was the participants' sole contact person. I recruited the participants, conducted the focus

group, provided the interview questions, answered questions related to the study, gave instructions to the participants, conducted the interviews, and collected and analyzed the data. I am comfortable and confident in this role because I am a local resident of Stockton, California. In addition, I have been a community advocate for Cambodian immigrants, I can speak the language fluently, and I fully understand cultural appropriateness when speaking and interacting with elderly Cambodians. Additionally, as a program administrator, health advocate, community leader, educator, and community organizer, I am aware of the different approaches to use with different groups and individuals. I have over 13 years of experience in facilitating groups, workshops, lectures, and one-on-one on issues relating to health and mental health. I am also familiar with using motivational interviewing strategies to engage participants. Finally, I understand the importance of establishing trust and rapport with the participants. It is imperative to respect and honor confidentiality, and to listen objectively to the participants.

Research Limitation and Potential Bias

A limitation of the study is the small sample size, which prevents the study from being generalized to a larger community (see Creswell, 2003). In addition, because of my experience as a Cambodian immigrant, I have to be mindful of my own experience and the way I ask questions. I need to be aware not to ask leading questions that could potentially affect the results of the study. To mitigate this potential bias, I asked each participant the same questions verbatim and refrained from engaging in personal conversation or discussion outside of the study questions.

Summary

In summary, I used a qualitative design to create a more detailed understanding of PTSD in the Cambodian immigrant community in Stockton, California, the historical factors affecting PTSD for the participants, and the socioecological elements involved in access to healthcare. The semi structured, open-ended interviews used for this study provided the structure for an objective and holistic approach to determining the outcomes. I used coding to determine the themes derived from the interview data. All data outcomes were checked for accuracy and consistency, and were labeled and recorded appropriately.

This study can be beneficial to the Cambodian immigrant community and service providers working to understand and support an ecological approach in mental health engagement and intervention among this unique immigrant community. It is also imperative for the Cambodian community to understand the interrelationship between PTSD, genocide, immigration experience, and the complex social phenomena associated with this area of investigation.

This study can have the potential for positive change in the mental health system of care because it presents mental health providers with opportunity to learn how to be culturally responsive when providing treatment to a culturally diverse community. PTSD can have significant effects on the individuals and family members suffering from it. For early detection and early interventions to be effective, members of the diverse communities and providers need to be informed of the historical and cultural experiences that influence the perceptions of PTSD among different groups.

Chapter 4: Results

Introduction

The purpose of this phenomenological study was to explore how Cambodian immigrant community perceive and interpret post-traumatic stress disorder (PTSD). In this chapter, I present an analysis of the findings from 13 semi structured interviews with Cambodian immigrant community members living in Stockton, California. I used open-ended interview questions to gather in-depth data on various factors such as knowledge, understanding, personal experiences, cultural practices, and cultural interpretations that may influence the Cambodian community's perceptions of and access to mental health services, support, and treatment for PTSD. I developed open-ended questions in the interview protocol to allow for clearer and deeper answers to the four research questions that are the foundation of this qualitative study. The rate of PTSD in the Cambodian immigrant community is higher than 65% (Marshals et al., 2000). While behavioral health service providers know this information, there is a dearth of current research about the how much knowledge the Cambodian immigrant community know about the meaning, treatment options, and factors related to PTSD that prevent them from getting the help that they need from the mental health system.

The central research questions addressed in this phenomenological study were the following:

RQ1: How much knowledge do Cambodian immigrants in Stockton know about PTSD?

RQ2: What barriers prevent the Cambodian immigrant community from accessing mental health services?

RQ3: What are some cultural healing practices and coping skills used for helping Cambodian immigrants in Stockton who have PTSD?

RQ4: What knowledge do the Cambodian community have about mental health/behavioral health resources in San Joaquin County, and do they know how to and where to access the resources?

This chapter provides a summary of the emerging themes observed from the results of the interviews. The information in this chapter is organized into subsections on the pilot study, research setting, characteristics of study sample, demographics, data collection, data analysis, trustworthiness, and results.

Pilot Study

I used a pilot study to test the validity and reliability of the research questionnaire. The pilot study recruitment and data collection process began after I received approval from the Walden University IRB. According to Van Teijllingen and Dundley (2002) pilot studies are "small methodological tests" used to ensure that the interview protocol, interview questions, and research instruments are consistent and clear for all research participants (p. 191). I conducted a pilot study with two members from the Cambodian immigrant community residing in Stockton, California. The participants for the pilot study included one male and one female. I met with both participants to explain the purpose of the study and the consent form, completed the informed consent, and secure permission for digitally recording the interviews. The pilot study was helpful in preparing

for the actual semi structured interviews. The pilot study revealed valuable information relating to the interview methods and sequence of the interview questions. Based on the pilot study, I revised and adjusted the interview questions, terminologies, and the sequences of the questions to allow for better fluidity.

Research Setting

I conducted this study in Stockton, California between June 10, 2017 and August 20, 2017. Approximately 250 flyers were disseminated around Stockton. These flyers were distributed at the Cambodian temples, grocery stores, apartment complexes where the Cambodian community resides, Angel Cruz Community Park where Cambodian community members often meet to socialize and eat food, and all Cambodian restaurants in Stockton. The semi structured one-on-one interviews took place in the back corner of the San Joaquin Delta College library. This location is available for public use, easy to find, accessible to all participants, and provided the needed privacy. Prior to the interview, I prepared an interview folder for each participant and reviewed the interview protocols before the actual interviews. I locked the information gathered from the participants in a secured and locked file cabinet at my house. Digital recordings were locked in a locked box inside the locked file cabinet.

Demographics

Participation criteria were limited to members of the Cambodian immigrant community living in Stockton, California. The study included 13 participants. The strategy I used purposive sampling to recruit participants and increase the diversity in the sample pool. Demographic inclusion criteria were established during the recruitment

process. These criteria were identified in the recruitment flyers and in the brief demographic survey provided to each participant prior to the one-on-one interview. Table 1 provides the demographics of the participants, including gender, age, year immigrated to United States, level of education, family lived through the genocide, and family lived in the refugee camp. The sample consisted of 10 females and 3 males. During the interviews, I realized that 12 out of the 13 participants had never heard of or known about PTSD. For me to proceed to the rest of the questions, I had to explain the scope of PTSD to the participants.

Table 1.

Demographic Information

First name	Gender	Age range	Highest level of education	Approximate year family immigrated to the U.S.	Family lived through the genocide	Family lived in the refugee camp
Thea	F	31-40	High School	1981-1985	Yes	Yes
Chanti	F	18-30	High School	1979-1981	Yes	Yes
Vegniasha	F	18-30	High School	1981-1985	Yes	Yes
Varun	F	61-70	Elementary School	1979-1981	Yes	Yes
Jackie	F	61-70	College	1975-1979	Yes	Yes
Chantha	F	41-50	High School	1981-1985	Yes	Yes
Chantham	F	51-60	High School	1979-1981	Yes	Yes
Sophy	F	41-50	Never attended school	1981-1985	Yes	Yes
Sarah	F	18-30	College	1979-1981	Yes	Yes
Ly	F	51-60	High School	1979-1981	Yes	Yes
Lim	M	41-50	High School	1979-1981	Yes	Yes
Sam	M	51-60	High School	1979-1981	Yes	Yes
Adrienne	M	31-40	Middle School	1979-1981	Yes	Yes

Figure 1. Map of Stockton, California.

Data Collection

The data collection process included the pilot test and audio recording of the interviews. I used the pilot test to establish the validity of the interview instruments. After the interview instrument was validated, I began the actual study. The study consisted of 10 females and 3 males. The interviews lasted between 7 and 15 minutes. All the interviews were conducted between 5:00 pm and 8:00 pm. I used the questionnaires in Appendix D as a blueprint to guide the face-to-face interviews.

During the face-to-face interviews, I used the open-ended technique to dive deeper into some of the questions. To keep the participants comfortable, I did not make any notation during the face-to-face interviews. I noted my observations of the facial expressions and body language of each participant at the completion of each interview. Once the interviews were completed for that day, I listened to each recording and

transcribed each recording verbatim into a Word document. I listened to each of the interviews several times to ensure accuracy. Once all the audio recordings were transcribed, I hand coded the data and organized it by research questions. The interview transcripts were uploaded into NVivo 11 for further analysis.

Data Analysis

The data analysis consisted of digital recording of the interviews, transcription of the interviews, and the organization of the emerging themes in NVivo. I used NVivo 11 qualitative software from QRS International. Prior to uploading the transcript into NVivo 11, I replayed the recording of each interviews and simultaneously reviewed the transcripts and hand coded the transcripts to the research questions. After I confirmed that the information was accurate, I started uploading the transcripts into NVivo 11 and coded the interview questions into categories. I reviewed the interview responses, one question and one participant at a time, and highlighted the responses into the main themes. From this coding method, several themes emerged based on the frequency of words.

Evidence of Trustworthiness

Trustworthiness is critical in research studies. In quantitative research studies, the trustworthiness comes from the validity and reliability of the study's instruments (Creswell, 2012). However, for qualitative research, trustworthiness depends on the following core four components in the research study's findings: credibility, transferability, confirmability, and dependability. To verify and ensure the credibility of this study, I made sure to be familiar with the process, the interview questions, and the need for participants to be aware of the purpose of the research study. I used digital

recording to capture the participants' answers and used the recording to transcribe the participants' responses.

Transferability

In order to ensure transferability, I provided detailed descriptions of the research method, data collection, procedures, and participants' experiences through data collection. These descriptions were established through field notes, the verbatim transcriptions of the interviews, and observations. The field notes allowed additional descriptions of the shared cultural beliefs of the phenomenon. The direct quotes from the verbatim transcriptions provided the rich descriptions during data analysis.

Dependability

To ensure the dependability of this study, I maintained an audit trail. Every part of the research process was documented and recorded for safekeeping. NVivo 11 software was used to upload the transcripts for data analysis. This software is one resource that provides an electronic tracking system. The audio recordings for the data collection were secured for future reviews.

Confirmability

To ensure conformability, I focused on the participants' answers and used self-reflection to ensure that the data collected and analyzed were based on the participants' responses only. I also documented my observations throughout the entire process to ensure that I was not interjecting my personal values into the data analysis.

Emerging Themes

This section addresses the themes that emerged from the data analysis in response

to the research questions. One of the most common forms of analysis in qualitative research is thematic analysis (Creswell, 2009). In this thematic analysis, I looked for repetitions in the responses and key words from participants. Both repetitions and key-words-in-contexts are two of the eight observational techniques in a qualitative data analysis that assist in identifying emerging themes (Ryan & Bernard, 2003). A brief overview of the themes that emerged from research questions is illustrated in Table 2. These themes emerged from the data analysis process.

Table 2.

Emerging Themes

Core themes (15)	*n*	Frequency of responses
Meaning of PTSD	13	29
Heard of PTSD	13	13
Contributing factors	13	18
Healing practices	13	23
Reactions	13	15
Support from mental health	13	19
Counseling	7	16
Agencies and Access	13	12
Medications	13	20
Mental Health resources	13	12
Ways of helping	13	20
Reasons often given	13	17
Recognition of PTSD	12	27
Urging family members	13	11
Need more information	13	19

Research Question 1

Research Question 1 asked: What knowledge do Cambodian immigrants in Stockton have about PTSD? The question addressed the knowledge and perception of PTSD among Cambodian immigrants in Stockton, California. The core themes that emerged during the data analysis are as follows: (a) meaning of PTSD, (b) heard of PTSD, (c) recognition of PTSD, (d) contributing factors, (e) reactions, and (f) medication. Research Question 1 themes correspond with the following interview questions (IQs):

- IQ1: Describe what the word post-traumatic stress disorder means to you.
- IQ2: Describe what you think cause Cambodian people to develop PTSD.
- IQ3: Describe what life factors that contribute to PTSD
- IQ4: Do you think you would be able to recognize the symptoms of post-traumatic stress disorder? Why or why not?
- IQ7: What are your reactions to someone experiencing post-traumatic stress disorder? Are you afraid of them? Do you feel sorry for them? Why do you think you feel that way?
- IQ8: Do you think a person can be cured of PTSD? What do you think they would have to do? What do you think mental health services could do for a person with PTSD?

Theme 1: Meaning of PTSD. During the interviews, all 13 participants responded to IQ1. Ten out of 13 responses were, “I don’t know what PTSD is and have not heard of the term,” and “I’m not too sure what it means.” Only three participants had

heard of the words post-traumatic stress disorder. Sarah said, “I heard of PTSD from school and I think it’s a mental illness where people developed severe fear of something bad that happened to them.” Dara said, “I don’t know too much about it.” Chantha said, “I don’t really know or understand what it is. I have never heard of these words.” Chantham responded, “Actually, I haven’t heard of these words at all and I don’t really know what PTSD look like.”

Theme 2: Hearing of PTSD. All 13 participants responded to IQ2. Jackie said, “No, I never heard of this term, but I have heard of stress.” Sarah said, “No. I have not heard of it, but I would like to know about it.” Adrienne responded, “No, this is something new to me. I don’t know what it is.” Chanti said, “Yes, I have heard of it. I hear it in movies and at school. I don’t know exactly what it is.” Thea said, “I heard of it from crisis and I think I was living with someone who has it.”

Theme 3: Recognition of PTSD. Twelve of 13 participants responded to the interview IQ3. Sophy said, “I don’t know the meaning of it. But I think it is something that makes people really sad because of many losses.” Sarah said, “I think it will be easy to see because the person would be angry, sad, grouchy, and just want to be alone all the time.” Varun said, “I would think the person would be sad and quiet because they are hurt.”

Theme 4: Contributing factors. All 13 participants responded to IQ4. Om said, “I think having loss everything in the war and going through a lot of sadness and dangerous situation and without support.” Nary said, “I think the war. My parents went through it and I know it effect how they feel about life sometimes.” Lim said, “I’m not

too sure, I will guess the war and leaving their country and coming here with nothing." Sam said, "The war, the Pol Pot war and Cambodia have been at war for thousands of years."

Theme 5: Reactions. All 13 participants responded to IQ7. Sina said,

> We have to feel sorry and not afraid. They are hurting. We have to understand what they went through and get to know them, share stories with each other and get to know each other. It's sad. I feel sad and hurt for them.

Sophy said, "I would feel more sorry for them, but in a way, I am more afraid of them in some way because I don't know how extreme or how bad they have the problem." Thea said, "I would feel both. Who knows what they can do because they don't know how to act to the world and society, but also, sorry because of the fear, can't sleep, they feel trapped, bad memories. That is sad."

Theme 6: Medications. All 13 participants responded to IQ8. Adrienne said, "I don't think the medications will help. If they have something with the mind, we need to help them keep their mind strong. Medications will make them go crazier." Lim said, "I don't really know much about medicine for stress. I did hear from people who have taken medications from mental health that medications make them feel like hurting themselves and some are addictive." Ly said, "I think medications can help, if it's the right medications."

Research Question 2

Research Question 2 asked the following: "What barriers prevent the Cambodian immigrant community from accessing mental health services?" I asked each participant

to explain the reason for not getting help from mental health services if they thought they had PTSD or thought their family members had PTSD. Two major themes emerged from this question: (a) reasons often given and (b) urging family members. Research Question 2 themes corresponded to the following interview questions:

- IQ5: If you thought you had PTSD, can you think of some reason you wouldn't want to seek mental health services?
- IQ6: Would you urge a family member to seek mental health services if you thought they had PTSD? Would you go with them to get help?

Theme 7: Reasons often given. All 13 participants responded to IQ5. Dara said, "If I knew I had it, I would get help. The only reason that I wouldn't is maybe because I don't know where to go and afraid other people might think I'm crazy or something." Thea stated the following:

> Shame. It's just embarrassment to know that you have it, that it's an illness. It's an everyday battle of fear and shame. Society is not always accepting. I'm afraid that people might look at me different and the judgement from the community.

Theme 8: Urging family members. All 13 participants responded to IQ6. All of the participants stated that they would urge their family members to get help and would go with their family members to mental health.

Research Question 3

Research Question 3 asked the following: "What are some cultural healing practices and coping skills used for supporting someone with post-traumatic stress disorder among Cambodian immigrant community?" Research Question 3 involved

examining the healing and coping practices among Cambodian immigrant community in Stockton, California. I asked the participants to identify healing and coping practices that would make them or someone else feel better if they had PTSD. Three main themes emerged from the interviews: (a) healing practices, (b) ways of helping, and (c) counseling. research question 3 themes correspond to interview questions:

- IQ9: What would be your way of helping or supporting someone heal from post-traumatic stress disorder?
- IQ10: Do you feel that taking medications will help with treatment of posttraumatic stress disorder? Why or Why not? Have you heard if medications help with PTSD?
- IQ11: What other healing practices do you think would help with posttraumatic stress disorder?

Theme 9: Healing practices. All 13 participants responded to IQ9. Carrie said, "Well, in the Cambodian culture, talking about it to close family members and monks can help. Praying and practice spirituality can also help." Vigniasha said, "Sometimes my parents go to the temple to chant and pray. They do that at home too. So, praying or going to the 'kru' to chase away bad spirits might help." Adrienne said,

> For my Dad, his beliefs in God and Buddha was his healing practice. It helped him a lot to calm down. When I was a kid, my Dad was a different person. Once he changed to religion, he changed a lot. He prays to Buddha, he got his own shrine, and he prays to Buddha. When my mom was still alive, they go to the temple, pray, give rice to the monks, and give offering (bon). When it's me and

> him. He used to tell me a lot of stories about my uncle, his father, his cousins, his friends, when he was in the military and stuff. And about religion. He likes to talk about (bon) and karma.

Pu Sam added, "For me, it's religion, praying, and meditating. That's what makes me feel at peace for a moment."

Theme 10: Ways of helping. All 13 participants responded to IQ10. Dara said, "I think as human, the basic approach would be to just be there for them. Be there for the one you care about to listen and be non-judgmental." Ming Srey said,

> When people are not well, it's important to be there for them no matter what and tell them that they will be ok. Getting them out of the house and go places so are not stuck and isolated in the house. That makes the problem seems worse. Talking to them. Be there for them.

Lim said, "Be there for them no matter what. Also, exercise can help people feel better. But the most important thing to always remember is that having a good support system is important." Thea said, "Love and care for them and be there for them. Talk to them and make them forget."

Theme 11: Counseling. Seven out of the 13 participants also mentioned counseling. Dara said, "I think meditation would really help calm the mind. Counseling too, but with someone who can understand the history about what Cambodian people went through and can understand the culture and language." Sophy said, "I would tell them to go find a facility that they can go to talk about their problem, something like talking to a counselor."

Research Question 4

Research Question 4 asked the following: "What knowledge do the Cambodian community have about mental health/behavioral health resources in San Joaquin County and do they know how and where to access the resources?" Research Question 4 addressed the level of understanding of the mental health services and the knowledge of resources provided by mental health services among Cambodian immigrant community in Stockton, California. The interview questions that were asked for this research question were related to the participants' ability to provide at least two local mental health locations, knowledge of what is provided, and what to do in case they needed to get help. Three main themes that emerged from this research included the following: (a) support from mental health, (b) mental health resources, and (c) agencies and access. The Research Question 4 themes correspond to the following interview questions:

- IQ12: What are some things do you think the mental health system is currently doing to help support individuals with post-traumatic stress disorder?
- IQ13: Can you tell me what you know about mental/ behavioral health resources in San Joaquin County and can you tell me two mental health locations?
- IQ14: Can you list two contacts, persons, or agencies that you can contact to get information to get referral for mental health, and how to access services?
- IQ15: Do you think the Cambodian community is informed about mental health services? Why or why not?

Theme 12: Support from mental health. All participants responded to IQ12. Chantham said,

> I don't think Cambodian people know about mental health services. I think Cambodian community are afraid of the words mental health, so they don't talk about it. I don't know if people are talking about it or information are being shared. I heard there is a mental health hospital in Stockton, but I have no clue where it is.

Vigneshia said,

> I honestly don't think people know. I think Cambodian people are afraid of going to mental health because they are afraid that other people in the community think that they are faking the illness to get money. This is a shameful thing. I think if people know more about it, it might help the Khmer community to get help.

Theme 13: Mental health resources. All 13 participants responded to IQ13. Thea said, "This is hard. I don't really know, but I think people go to mental health just to get money to support themselves. But they stop going once they get the SSI money, they stop going." Pu Sam said, "I heard that mental health gives medications and therapy." Lim said,

> I don't know what mental health is or what they do for people. It sounds scary to me to go to mental health. I didn't really pay too much attention of all the stories, but it sounds like a place full of people walking around like zombies.

Theme 14: Agencies and access. All 13 of the participants responded to IQ14, "Can you list who contacts, persons or agencies, that you can contact to get information

about mental health and how to access services?" Jackie said, "One on California Street and the other one on Pershing. I've never been there personally, but I've seen it." Dara said, "I don't know. I haven't heard about it and I definitely have no clue about accessing it." Sarah said, "Sorry, I don't know. Do I go through the doctor's office?

Theme 15: Need more information. All 13 of the participants responded to IQ15. Andre said, "I don't think Cambodian people know too much about mental services. I lived here all my life and I don't even know. We need more information." Ming Srey said, "I hope someone from mental health can do a presentation to the community so we know what mental health is about. I want to know more."

Summary

After the interviews and reviewing all the transcripts, I had a better understanding of the community's perception and interpretation of PTSD and their needs for better understanding. After the coding process, 13 core themes emerged to support the four research questions. Almost all the participants had not heard of the term post-traumatic stress disorder and did not know about post-traumatic stress disorder, but were aware that the war and genocide played a role in PTSD due to the overwhelming life stressors. Many of the participants turned to religion, spirituality, spiritual healers, close friends, and trusted family members for comfort and healing. Praying, spirit washing, and talking to a trusted friend were shared by the participants as coping skills to deal with major life challenges, including PTSD. The responses demonstrated that the Cambodian immigrant community needs more information and education about the mental health system. The lack of knowledge about the mental health system, mental health services, and how to

access services were the main contributing factors to barriers of accessing mental health. The negative perception and stigma towards the word “mental health” is also another barrier that prevents the Cambodian immigrant community members from getting the help that they need.

Chapter 5 illustrates the connection between the 13 themes that emerged from the interviews, data collection, data analysis, and findings from the study to the literature presented in Chapter 2. Chapter 5 also includes study findings, limitations, implications for social changes, and recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to explore to explore how Cambodian immigrant community perceive and interpret post-traumatic stress disorder (PTSD). A sample of 13 Cambodian community members participated in the study. The objective of the study was to gain a deeper understanding of Cambodian immigrants' perceptions and interpretations of what PTSD is to get a better grasp on the challenges they face in accessing mental health services. I analyzed interview data to identify themes that I used to guide the interpretation and discussion of the findings. The study findings I report in Chapter 4 provided deep insight on the cultural perception of what PTSD is in the Cambodian immigrant community and how these cultural perceptions influence the community's willingness to access mental health services in Stockton, California. Chapter 5 contains a detailed discussion of the study findings, which include the themes that emerged from the research questions, the relationship of the themes to the existing literature, recommendations for the county mental health system, suggestions for future research, and the study's limitations.

Interpretations of the Findings

The findings from this study may help the county's behavioral health system find better ways to engage, educate, and provide culturally appropriate mental health services to immigrant communities. The research findings highlight valuable information regarding perception and interpretation of PTSD among Cambodian immigrants. In the literature review, I demonstrated how mental illness, such as PTSD, is prevalent among

Cambodian immigrant communities; however, little is known about the relationship between how the perception of an illness can influence the rate of access for services. In Chapter 2, I also illustrated that although the rate of PTSD in Cambodian immigrant communities is high, the number of individuals accessing mental health services for help, support, and treatment continues to be very low (Marshals, et. al, 2003).

According to the United Nations High Commissioner for Refugees ([UNHCR], 2017), more than 65.6 million people worldwide are forcibly displaced from their homes because of war, political conflicts, and persecutions. The rise of displaced communities is one of the contributing factors to the high risk of psychopathologic disorder, including PTSD, among various groups of immigrants (Kirmayer et al., 2011). Understanding the cultural perception and meaning given of PTSD among Cambodian immigrant communities in Stockton, California can help broaden the collective understanding of many other immigrant communities in the United States.

The themes that emerged from this research study are consistent with the findings from the literature presented in Chapter 2. The themes include: (a) hearing of PTSD, (b) meaning of PTSD, (c) contributing factors, (d) healing practices, (e) recognition of PTSD, (f) reactions, (g) reasons most often given, (h) encouraging family members, (i) healing practices, (j) ways of helping, (k) counseling, (l) medications, (m) mental health support, (n) mental health resources, and (o) want more information. The results from this study add to the existing knowledge and fill the research gap for better understanding of cultural perceptions of PTSD and the barriers the Cambodian immigrant community in Stockton, California have to accessing mental health services. Bronfenbrenner's (1979)

SEM provided the theoretical framework for this study. The theory, as described in Chapter 2, provided a framework for explaining the interconnections among the microsystems, macrosystems, and chronosystems within an individual's social ecological structure, which contribute to how a group of community members learn and share information among themselves. The next section addresses the emerging themes for the study.

Research Question 1

The following was the first research question for this study: What knowledge do Cambodian immigrants community in Stockton have a bout PTSD?

Hearing of PTSD. According to Marshal et al. (2005) and Kiernan (2012), mental health related terminologies have different meanings in the Khmer language. For example, terms such as PTSD do not exist in conversations or in the vocabulary. During the interviews, only one of 13 participants had heard of the term "post-traumatic stress disorder." To proceed to the next question, I translated the words "post-traumatic stress disorder" into Khmer. When these words were translated, all of the participants were able to contribute their thoughts to what they think post-traumatic stress disorder means. The responses from the participants were very similar, despite not having prior knowledge of PTSD. This information is valuable for providers to know in order to identify areas of need regarding developing educational programs that raise awareness of PTSD among members of the community.

Meaning of PTSD. According to Hinton, Nickerson, and Bryant (2011), there is a strong correlation between worrying and the presence of PTSD. Hinton et al. (2011) also

claimed that “worry” highly induced the severity of PTSD symptoms, such as somatic arousal, catastrophic cognitions, trauma recall, irritability, and the inability to stop worrying. All of the participants mentioned the phrase “stress and worry” as part of their interpretation of what PTSD means. Many of the participants had not heard of the term post-traumatic stress disorder, although once I explained to them the definition, they became more open and shared words that they described as their perception of what PTSD means. These words and phrases included constant worrying, angry, irritable, thinking too much, sadness, and stress all the time. The expressed interpretation and meaning of PTSD among the participants were similar across all participants. Members of the Cambodian community have a saying, “kom proy chroeun piech,” meaning, “Do not worry too much.” The notion of “worrying too much” has become engrained in the psychosocial and cultural beliefs of the Cambodian community following many generations of war and hardship (Hinton et al., 2001). It is imperative that care providers are aware of the correlation between worrying and the presence of PTSD when identifying the best treatment options to support individuals in developing coping and symptom management skills.

Contributing factors. The data I gathered from the participants’ responses showed commonalities in participants’ understandings that war and genocide played a significant role in the mental and behavioral health challenges faced by Cambodian immigrant communities. Despite not knowing what PTSD was, as soon I explained the definition of PTSD to the participants, all were aware that (a) genocide and war in Cambodia were the main contributing factors in the development of PTSD, and (b) the

daily stress of acculturating into American society was and still is very stressful. One participant said, “Cambodian people goes through a lot in their life. The genocide, then coming to America with nothing; no money, being poor, no jobs, and don’t speak the language. That’s enough to develop mental issues.” This response resonated with Kiernan’s (2012) argument that the Cambodian immigrant community experienced sociohistorical circumstances that resulted in a significant shift in life transition. These life transitions and acculturation contributed to the constant “worry” and the exacerbation of symptoms related to PTSD.

Recognizing PTSD. During data collection, nine out of 13 participants mentioned that despite the lack of prior knowledge about PTSD, if they come across someone who might be experiencing symptoms related to PTSD, they would be able to recognize it. Several participants echoed similar descriptions of what they think the observable behavior of someone with PTSD would look like. The descriptions of PTSD, as shared by the participants, included the following words: sadness, isolated, angry all the time, grouchy, unpredictable, and quiet. Based on the responses, although some of these descriptions are accurate for some individuals challenged by the symptoms of PTSD, these descriptions appeared to be generalized with negative connotations attached. According to Kohrt and Harper (2008), the lack of knowledge and understanding of mental illness contribute to the stigma attached to the afflicted person. Stigma towards mental illness is one likely reason for the hesitation in seeking mental health services among Cambodian immigrants (Chung, 2010; Kiernan, 2012).

Reactions. Kramer et al. (2002) argued that the lack of knowledge and understanding of the root causes of PTSD and the fear of social rejection are two factors that keeps families from opening up about mental illness. Kramer et al.'s (2002) argument was consistent with some of the responses during data collection. For example, all participants shared their perception and reaction towards individuals with PTSD. Overall, the participants displayed empathy for individuals with PTSD. However, four participants expressed being fearful due the "unpredictability" of behavior. As one participant mentioned, "I feel sorry for someone with this problem, but at the same time, it's scary to be around someone with this issue because you don't know what they are thinking. Their mind is not in the right place." Based on this finding, 12 participants expressed empathy for those who might suffer from mental illness. However, on the contrary, the same participants who expressed empathy also expressed fear towards individuals with mental illness. The lack of knowledge and understanding of what mental illness entails may have contributed to the misperception of individuals with PTSD. Sometimes, the media portrays individuals with PTSD and mental illness in negative ways. Thus, community members who are not appropriately informed of the nature of the illness may perceive individuals with mental illness as "dangerous and unpredictable," as stated by one of the participants.

Research Question 2

The follow was the second research question for this study: What barriers prevent the Cambodian immigrant community from accessing mental health services?

Reasons often given. According to Kramer et al. (2002) and Marshall et al. (2005), Cambodian immigrants consider mental illness to be a private family matter; therefore, seeking outside help, such as mental health services, is perceived as exposing family business in the open. Further, culturally, Cambodians takes great responsibility in caring for their family members, so seeking outside help may be perceived as a lack of competency in caring for loved ones. In the Cambodian family structure, the family name, reputation, and honor are very important; therefore, family needs supersede individual needs (Kramer et al 2002; Marshall et al 2005). These findings from previous research align with the findings from the data analysis of the present study. Eight of 13 participants expressed that the reasons for not getting help include: (a) a fear that people would think they are crazy, (b) a fear of judgment and rejection by their family, community, or society, and (c) embarrassment for the family. One participant noted, "One of the reasons that I wouldn't get help is maybe because I don't where to go and afraid that people might think I am crazy."

Encourage help for family. Seven of 13 participants stated that if they knew their family member was in need of help, they would encourage their family member to seek mental health services, which appeared to be contradictory to the prior findings. When the participants were asked why they would encourage their family members, but would not get themselves the help, one participant stated, "If I knew my family member needs help, I would encourage them to get help and would be there for them, but how can I help myself if I might not even know I have a problem." This finding appeared to be in contrast with the research conducted by Kramer et al. (2002) and Kiernan (2012).

According to Kramer et al. (2002) and Kiernan (2012), prejudicial treatment of the person affected by mental illness and tarnishing of the family name are two likely reasons for hesitation in seeking mental health services. However, data from the present study reveals that family members are open to getting help for their family members if they were aware of their family member's challenges and needs.

Research Question 3

The following was the third research question for this study: What are some cultural healing practices and coping skills used for supporting someone with post-traumatic stress disorder among the Cambodian immigrant community?

Healing practices. According to Berkman (2006, p. 208), Buddhism plays an important role in Cambodian culture, beliefs, and traditions. Buddhists believe that suffering is a part a life (Buddha Dharma Education Association, 2015). The pain of losing loved ones during genocide is part of human suffering (Berkman, 2006, p. 208). To free the mind, body, and spirit from suffering, one must pray to the spirits of one's dead relative to set the relatives' soul free (Buddha Dharma Education Association, 2015). Participants expressed and echoed how important spirituality and praying was to the healing from emotional and mental pain and suffering. As one participant shared, "For me, it's religion, praying, and meditating that makes me feel at peace for a moment." Collectively, a common denominator among all participants that helps with dealing with the memories of what happened during the genocide was attending temple services to pray and give offering to Buddha and spirits.

Ways of helping. All 13 participants noted the best way of helping others who might be going through challenges relating to PTSD is "being there for them in a non-judgmental way." As discussed by Kramer et al (2002), Cambodian immigrants have a close-knit family structure; when there is a problem, it is very natural for the family and close friends to assist and support one another. One participant made this statement, which was commonly expressed among all participants, "When someone is not well, it is important to be there for them, no matter what, and they tell them they will be ok." Sanstrock (2012) explained the connection between the microsystem and macrosystem, which includes health status, family structure, and life circumstances. In this case, family members and close friends are very supportive of each other in their times of need. The circle of support and trust is very close-knit so, in terms of the access to care, it can present a challenge.

Counseling. Six out of 13 participants mentioned the openness for counseling services to help cope with PTSD. These data conflict with those of Kent (2006) who found that, because of the cultural beliefs and practices, many Cambodians seek healers and monks first before seeking anyone medically train for help. However, it appeared that some Cambodian immigrants have heard of mental health services and perceive counseling as a way of talking to someone instead of treatment. As stated by one participant, "I think counseling can be helpful if you talk to someone who understands the history, culture, and language."

Medications. According to Kohrt and Harper (2008), there is a socially shared misconception that psychotropic medications worsen the signs and symptoms of mental

illness. Nine participants expressed this shared belief during the data collection. Nine of participants stated that they "heard from others" that taking psychotropic medications can "worsen" mental health symptoms. One of the participants noted, "I knew someone who was just a little a sad, but she became crazy after she starts taking medications that she got from mental health." This shared misconception is prevalent among Cambodian immigrant communities, and the lack of the knowledge about the facts behind psychotropic medications as treatment for PTSD is a concern. These findings are consistent with research discussed in Chapter 2, which found that the lack of knowledge about mental illness among Cambodian immigrant community is one of the contributing factors to barriers in accessing mental health services (Marshalls et al., 2005).

Approximately 50% of the Cambodian community believed that mental illness is contagious; therefore, some family members would ban the marriage if one family believed the other family had members with mental illness (Kohrt & Harper, 2008). Due to the severity of this stigma and a lack of knowledge about PTSD, to "save face," a myth was spread that psychotropic medications worsened the signs and symptoms of the conditions and, at times, that these psychotropic medications could turn a normal person to a "crazy person" (Kohrt and Harper (2008). One participant shared this statement, "I heard that when you go to mental health, they give you medications that makes a normal person turn crazy." Another comment related to the belief that psychotropic "medications makes things worst" may be contributed to the lack of education about how psychotropic medications work and the importance of medication adherence. According to Fancher, Lee, Cheng, Yang, and Yang (2012) fewer than half of Asians take their psychotropic

medications as prescribed, due to the cultural beliefs surrounding medications, mental illness, and the stigma associated with it.

Research Question 4

The following was the fourth research question for this study: What knowledge do the Cambodian community have about mental health/behavioral health resources in San Joaquin County, and do they know how to and where to access the resources?

Mental health support. Knowledge about mental health services and supportive services continues to be a pressing issue among Cambodian immigrant communities (NAMI, 2014). Ten participants shared that they "do not have a clue about what support services are offered at mental health." According to Abraham (1996), a macrosystem is the overall pattern of ideology and organization in each society and includes attitudes, values, and beliefs commonly shared by societal group. In this study, members of the Cambodian immigrant community were not well informed about mental health services. Again, the lack of knowledge about the existing support and services presents a challenge and concern for the community in its members' ability to access and receive mental health services. The misconception of mental health and available treatments continues to plague the Cambodian immigrant community with fear. One participant stated, "Even if I want to get help, I don't even know what kinds of help are offered or if it's safe for me." This finding illustrates the need for more mental health outreach efforts into the Cambodian immigrant communities.

Mental health resources. According to Marshall et al. (2005), culturally responsive mental health services are in demand due to the increasing needs of mental

health support by diverse communities. The findings of this study reveal that participants are not aware of the mental health resources available in their community. Three participants reported that they had heard of mental health facilities, but were not aware of other resources. One participant stated, “The only thing I know about mental health is that they have therapist and doctors who can give you medications.” Only four out of 13 participants could list at least two local mental health agencies in Stockton, California. The lack of knowledge and awareness of the availability of mental health resources in the community present a challenge for accessing services. Another participant shared, “My mother passed away when I was young. I think it [was] related to mental illness, but because we didn’t know where to go or what to do, she had to suffer.” The statement of “I don’t know” echoed consistently through the interviews. This finding illustrates a great need for community education about a variety of aspects of mental health related information.

Want more information. All 13 participants expressed an eagerness to learn more about PTSD, mental illness, mental health resources, and mental health services. One participant noted that Cambodian immigrant communities are in need of help navigating the mental health system, understanding what mental health is, and were eager to get help. Another participant expressed the need for a Cambodian Community Center, where the community can go to access various types of information, mental health information included. The socioeconomic challenges presented within the Cambodian immigrant communities hinders the ability for Cambodian members to access services such as locating mental health programs, obtaining mental health information, receiving

mental health services, and adhering to treatments (Marshall et al, 2005). This need for information is consistent with findings related to the lack of knowledge and awareness of the overall understanding of PTSD, mental illness, and mental health services.

Limitation of the Study

The first limitation relates to the specific population of participants. This study focused on a Cambodian immigrant community in Stockton, California, which is not representative of all Cambodian immigrants in the United States. Additionally, the sample size for this research was 13. Small sample size does not reflect the entire population of Cambodian immigrants in the United States, although it is adequate for qualitative study (Leedy & Ormrod, 2010). Further, the inclusion criterion for this study called for participants who spoke fluent English, which excluded individuals who can speak only Khmer. Prior to conducting the pilot study, the interview protocols were validated by consulting the interview questions with an expert in the mental health field prior to the actual study and data collection process.

Delimitations

The delimitations of this study include the decision to select participants from a Cambodian immigrant community in the geographical location of Stockton, California, rather than expanding the study to include Cambodian participants for San Joaquin County. There are Cambodian communities who live in other surrounding cities within San Joaquin County; however, the choice of selecting just Stockton, California allowed the data to be focus on just this geographical region. Another delimitation pertains to the inclusion criterion of participants having to be over the age of 18, have had family

members who lived through the genocide and/or refugee camps in Cambodia, and who spoke fluent English. These delimitations helped to narrow the data collection in such a way as to tailor the information specific to sample population.

Significance of Findings and Social Implications

This qualitative research study explored how Cambodian immigrant community perceive and interpret post-traumatic stress disorder (PTSD). I wanted to understand how cultural perception and interpretation of PTSD could influence access and utilization of mental health services. More than 62% of Cambodian immigrant communities in the United States exhibit signs of PTSD; however, fewer than 5 % access and utilize mental health services in Stockton, California. Research studies in the area of mental health and Cambodian immigrant communities were scarce and often outdated; however, the need for culturally responsive mental health services is on the rise due growing needs of the diverse population, Cambodian immigrants included. From the data analysis, 15 themes emerged and were significant in addressing the research questions. These themes generated new information and knowledge to address the noted gap in literature and provided a bridge between the needs of the Cambodian immigrant community. This study has the potential to advance knowledge of PTSD among the Cambodian immigrant community as well as other immigrant communities who have shared similar historical trauma due to war and displacement. A deeper understanding and awareness as to how the Cambodian community understand and interpret PTSD could motivate behavioral health agencies to utilize culturally appropriate approaches in the outreach efforts, and could potentially bring about effective culturally responsive mental health services.

There are many areas where positive social change could take place because of this study. The result of this study may provide a catalyst for progressive change within the Cambodian immigrant community concerning how it carries a real potential for expanding general awareness and increasing the collective knowledge base of the community. The results may also provide the capacity among family members and friends to identify symptoms, and to be informed as to common facts, such as how, when, and where to access mental health services and relevant resources that are available in the community. Furthermore, the results from this study could operate as helpful guideposts to assist behavioral health administrators, program developers, and direct providers in developing culturally responsive trainings that could be more likely to meet the complex needs of the diverse communities in Stockton, California, than those methods and approaches presently employed. Most importantly, individuals who are now suffering, or may be vulnerable to suffering from PTSD would have a greater opportunity for, and likelihood to, access appropriate help, so that that he or she would be more likely to live a full, productive, and quality life with newfound hope and healing.

Recommendations

The emerging data and themes from this study add new information about the needs of Cambodian immigrant communities in Stockton, California. According to research findings, a lack of knowledge and understanding of what mental health and PTSD are contribute to the barriers in accessing and utilizing mental health services. This lack of knowledge also contributes to misperceptions and misinterpretations of mental illness, as well as those who suffer from challenges related to untreated mental illness.

The misperception and misinterpretation of mental illness contribute to stigma, fear, and non-adherence to mental health treatment and medications. Recommendations to the findings include the following: (a) mental health education to increase aware and knowledge about PTSD among Cambodian immigrant communities, (b) policy change starting in the county level to provide culturally responsive mental health services to diverse communities, and (c) continued outreach efforts to reduce stigma attached to mental illness.

Recommendation for Community Education

According to the findings, there is a need for more education about mental illness, mental health system, mental health services, mental health resources, and ways that they can support others in the community. Based on the socioecological model, the interconnectedness among the individuals, families, and the community is very powerful; therefore, utilizing members of the community to spread the information is the best approach. A model that had been utilized for community health information dissemination is the Promotoras de Salud model; also known as, the community health workers model (Andrews, Felton, Wewers, & Heath 2004; Swider, 2002). The Promotoras are the bridge between the communities they live in and the health agencies. The Promotoras are individuals who belong to the community they serve, and who share the same language and culture; most importantly, they understand the needs of their community (Andrews et al., 2004; Swider, 2002). As evident in the findings, Cambodian community members are eager to support one another. The Promotoras de Salud Model could provide an opportunity for peer mentorship and support in a culturally and

linguistically appropriate manner. This approach may enhance the knowledge and awareness about mental health and potentially reduce stigma toward mental illness.

Recommendation for Policy

The data collected during the interview reflect a challenge in the mental health system of care. As observed from the emerged themes, these challenges include the lack of knowledge about mental health services, mental health resources, language barriers, and stigma. Given these challenges, it is imperative for policymakers to adopt ways that enhance cultural outreach to share information and facts about mental illness, mental health services, and navigating the mental health system. Additionally, local mental and behavioral health providers should be required to complete cultural competency training that not only discusses the culture, but which also incorporates the historical background of each culture in order to understand the factors relating to the migration or immigration into the United States. Further, training should incorporate trauma-informed care to enhance providers' skills and knowledge in supporting individuals who have experienced traumatic events.

Recommendation for Future Research

Based on the findings from the 13 participants, future research recommendations include expanding sample size and to other immigrant communities (Marshall et al, 2005). Expanding the sample size could potentially increase information power—more participants, more information. Future research should also incorporate Khmer-speaking participants to expand a larger and inclusive pool of Cambodian immigrant communities. By expanding the research pool to other immigrant communities, it may be possible to

help providers provide culturally responsive mental health services. According to UNHCR (2016), displaced persons have reached the highest level to date, which includes displacements due to war, political conflicts, and natural disasters. These events affect various groups of diverse communities and correlate to the increased rates of trauma Nilamadhab and Bastia (2006). Different cultures may perceive trauma and traumatic events differently; therefore, expanding research to different communities could be key to improving the collective knowledge.

Dissemination of Findings

This study could potentially increase knowledge and awareness for mental health providers, encouraging them to be mindful when working with diverse and immigrant communities. Additionally, this study could potentially increase knowledge and awareness about PTSD and mental health services among Cambodian immigrant communities. I intend to conduct presentations and seminars for various mental health agencies to raise awareness about the perceptions and interpretations of mental health and PTSD among Cambodian immigrants. I will also conduct presentations and seminars for the Asian Pacific Islanders Coalition and Cambodian immigrant communities. I will present these findings to the San Joaquin County Consortium and San Joaquin County Substance Abuse and Behavioral Health Board in addition to seminars and workshops in colleges and universities to students enrolled in programs such as medicine, nursing, psychology, teaching, and social work. I also plan to contact the local college and community radio programs to share information about this research study. Further, I will publish articles in newspapers, magazines, and academic journals to disseminate the

knowledge obtained from this study. Finally, I will do a record a video presentation and share it on social media and YouTube.

Conclusion

This study provided me with the opportunity to gain a valuable understanding of the perceptions and interpretation of PTSD among a Cambodian immigrant community in Stockton, California. The purpose of a mental health system is to support individuals who suffer from mental illness in regaining hopes and dreams through recovery to improve their quality of life (NAMI, 2017). Untreated PTSD can hinder a person's quality of life (NAMI, 2017). As reported by Marshalls et al. (2005), more than 60% Cambodian immigrants suffer from some form of trauma. However, fewer than 5% access and receive services, meaning that approximately 55% of the Cambodian immigrant community does not receive the help or support that its members need. For those who receive services, the services may be culturally inappropriate due to a lack of understanding of historical and cultural implications (Marshalls et al., 2005). The knowledge and understanding from this research study can bridge that gap.

It is imperative to share results from this research with the Cambodian immigrant community because of the potential effect that it could have on perceptions of seeking help from mental health services. The information shared by the participants may allow other members of the Cambodian community to feel that they are not alone in their perceptions, interpretations, thoughts, and feelings about PTSD and, more broadly, the mental health system. This information also provides an avenue for members of the Cambodian community to initiate dialogue with each other regarding their needs. More

importantly, one important theme that emerged from the data analysis pertains to illustrating that some members of the Cambodian community are eager to help and support others who need help. This information is valuable in encouraging members of the community to reach out for support.

In addition, upon reviewing results of this study, I felt enlightened by how receptive and eager members of the Cambodian immigrant community were to learn more about PTSD, mental health, and the mental health system. The lack of individuals accessing and utilizing mental health services is not because they do not want help, but stems from a lack of understanding and knowledge about these services. The Cambodian immigrant community has needs and these individuals are aware of the challenges related to mental health among members of their community. However, they lack information regarding how to navigate the mental health system of care. The results of this study allowed me to see and share existing problems with policy makers and other stakeholders. When the evidence we collect reveals a probable correlation to the factors that contribute to such a problem, then we can begin to address that problem more effectively.

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Appendix A: Interview Protocol

You are invited to take part in a research study of the Cambodian immigrant community in Stockton, California. The researcher is inviting men and women in Stockton, California to be in the study to help learn how this community understands and interprets signs of Post-Traumatic Stress Disorder (PTSD). This form is a part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Raksmey Arun Roeum-Castleman who is a doctoral student at Walden University.

Background Information:
The purpose of this study is to learn how the Cambodian immigrant community in Stockton, California interprets the signs of post-traumatic stress disorder (PTSD). My family and I live in Stockton, California. I often attend community gatherings with my family and have heard many stories about members of the community who have families and friends who have difficulty sleeping due to nightmares, can't leave their home because of anxiety, and use substances to deal with their challenges. These things appeared to be signs of PTSD; however, members of the Cambodian community are hesitant in seeking the help despite the available services. Given the high prevalent of PTSD among the Cambodian immigrant community, I hope to learn of the barriers that prevent the community from accessing the help that they need. Most specifically, I want to know how knowledgeable they are about signs of PTSD and how they interpret what it is so I can appropriately support the community in accessing services that is culturally appropriate.

Procedures:
If you agree to be in this study, you will be asked to:

- Read statement defining criteria for inclusion into the study and agree/disagree
- Participate in an interview, which should last no longer than 1 hour.
- Answer open-ended questions

Inclusion criteria of Cambodian immigrant community:

Individuals who are 18 years and older, Cambodian, reside in Stockton, California, have family member who lived through the genocide and/ or the refugee camp.

Exclusion criteria:

Individuals will please exclude themselves if they meet the following criteria: Under 18 years of age, pregnant, subordinate of the interviewer, personally know the researcher, student of the interviewer, client or potential client of the interviewer, and diagnose with PTSD.

Here are some sample questions:

- Have you heard of the term post-traumatic stress disorder?
- What do you know about post-traumatic stress disorder?
- In your opinion, what factors do you believe contribute to someone developing post-traumatic stress disorder?

Voluntary Nature of the Study:
This study is voluntary. You are free to accept or turn down the invitation. No one will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as becoming sad or upset remembering stories about the trauma that his or her family went through the genocide and/or the refugee camp. Being in this study would not pose risk to your safety or wellbeing.

This study involves a sensitive topic (i.e., that could be a trigger for distress, depression, etc.), the contact information for a free 24 hour support hotline is the San Jaoquin County warm line and support (209) 468-8686.

The reason why I am pursuing this study is to help service providers better understand how the Cambodian immigrant community interprets signs of PTSD and the mental health system. By interviewing members of this community and learning how they cope with challenges related to trauma and how they perceived the mental health system, service delivery or implementation provided for this community may be improved.

Payment:
A $20 gift card will be offered at the end of the interview.

Privacy:
Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by password protected computer files, with access only to this researcher and dissertation committee members. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You may ask any questions you have now. Or if you have questions later, you may contact the researcher, Raksmey Roeum-Castleman, at Raksmey.castleman@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is _____ and it expires on _____.

The researcher will give you a copy of this form to keep.

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix B: Interview Questions

1. How is post-traumatic stress disorder understood among Cambodian immigrants in Stockton?

    a. *Have you heard of the term post-traumatic stress disorder?*

    b. *What do you know about post-traumatic stress disorder?*

    c. *In your opinion, what factors do you believe contribute to someone developing post-traumatic stress disorder?*

    d. *Do you think you would be able to recognize the symptoms of post-traumatic stress disorder?*

    e. *A lot of people from the Cambodian community have PTSD. What experience do you think contribute to this?*

    f. *What do you think causes PTSD? Think about your experiences coming here from Cambodia. Do you think anything in those experiences might cause a person to have PTSD?*

    g. *If you thought you had PTSD, can you think of some reason you wouldn't want to seek mental health services?*

    h. *Would you urge a family member to seek mental health services if you thought they had PTSD? Would you go with them to get help?*

    i. *What are your reactions to someone experiencing post-traumatic stress disorder? Are you afraid of them? Do you feel sorry for them? Why do you think you feel that way?*

2. What are some healing practices and coping skills used for helping individuals who have post-traumatic stress disorder among Cambodian immigrants in Stockton?

    a. *What would be your way of helping someone heal from post-traumatic stress disorder?*

    b. *Do you think a person can be cured of PTSD? What do you think they would have to do? What do you think mental health services could do for a person with PTSD?*

    c. *Do you feel that taking medications will help with treatment post-traumatic stress disorder? Why or Why not?*

   d. *What kinds of things do you think the mental health system is currently doing to help support individuals with post-traumatic stress disorder?*

3. What knowledge do you have about mental/ behavioral health resources in San Joaquin County and do you know how and where to access the resources?

   a. *What support do you provide to someone who appeared to be suffering from post-traumatic stress disorder?*

   b. *Who would you contact if you wanted to access mental health services?*

   c. *Would you urge a family member to seek mental health services if you thought they had PTSD? Would you go with them?*

   d. *Do you think a person can be cured from PTSD? What do you think they would have to do? What do you think mental health services could do for a person with PTSD?*

   e. *Are there any additional comments and, or, concerns that you wish to make regarding your experience or thoughts about post-traumatic stress disorder?*

Appendix C: Participant Interview Log

Participant Number	Participant Identification	Date of Interview
1	Dara	07/08/2017
2	Ming Ly	07/08/2017
3	Sarah	07/08/2017
4	Ming Srey	07/08/2017
5	Sing	07/10/2017
6	Jackie	08/01/2017
7	Chantu	08/01/2017
8	Om	08/03/2017
9	Adrienne	08/05/2017
10	Sam	08/06/2017
11	Sina	08/06/2017
12	Nary	08/06/2017
13	Thea	08/09/2017

Appendix D: Demographic Data

These questions are developed to gather demographic information about the participants.

1). Age

a. 18-30

b. 31-40

c. 41-50

d. 51-60

e. 61-70

2). Gender

a. Male

b. Female

3). What is the highest level of education you've completed?

a. Elementary School

b. Middle School

c. High School

d. College

e. Never attended school

4). Year family immigrated to the United the States

a. 1979-1981

b. 1981-1985

c. 1986- 1990

5). Did your family live through the genocide?

a. Yes

b. No

6) Did your family live in the refugee camp?

a. Yes

b. No

Appendix E: Recruitment Flyer

Are you: 18 years and older, Cambodian, fluent in English, have at least a family member who lived through the Cambodian genocide and/or the refugee camp, and live in Stockton, California?

- Have you heard of PTSD? Do you have what PTSD is? Do you know how to support someone with PTSD?

If you meet the criteria above, you are invited to participate in a research study to explore the cultural perceptions of post-traumatic stress disorder among Cambodian immigrant community. This research study will be conducted by Raksmey Castleman, Walden University's Doctoral Student within the Department of Health Sciences. The study involves a one-hour in-depth interviews about your perception around post-traumatic stress disorder. For further information regarding this study, please contact Raksmey Castleman at email: Raksmey.castleman@waldenu.edu.